

**Beyond Reform:
Better Healthcare For Less**

Framework For The Future: A Strategic Healthcare Survival Kit For Employers

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Beyond Reform

We want health care to be abundant, effective, easy, and cheap; for too many of us too much of the time it is scarce, ineffective, maddeningly difficult, and far too expensive. It has become an unspeakable burden to employers, a cost beyond their control, an ever-growing tax, a sap on productivity—and starting in 2014, carrying that burden will no longer be optional. Employers will have to carry it or be fined.

But these very pressures are creating a revolution in healthcare that offer a practical way out for employers, a way that offers better healthcare, and better health, to employees, at a lower cost to both employees and employers. This revolution in health care is emergent, it's happening now. It's not simple, it's complex. It's hard to explain, it's sometimes hard even to notice, even if you're doing a piece of it. It's not political. It's not about rationing. It's not about abating symptoms, it's about healing the system, because the dysfunction in health care is deeply systemic.

A range of powerful vectors are coming together right now to make this the period of the most rapid and far-reaching change in the history of healthcare. These vectors will shift the marketplace of healthcare, changing every structure and every relationship to render the system as a whole far more lean and effective than it is today. Though not recognized yet as a movement, a revolution, a wave, the new structures and relationships are already emerging.

I have been an independent healthcare futurist and analyst for 30 years. I'm on the faculty of (and write for) the American Hospital Association and the American College of Physician Executives. I speak all over the industry. I'll tell you what I feel about the future of healthcare: If somebody doesn't pull a rabbit out of a hat some time real soon now, we are in serious trouble.

The good news? There is a hat, and it has a rabbit in it. Handfuls of rabbits.

Here at Imagine What If, we do a constant scan of healthcare, through the published literature, online blogs and email, and through constant contact with a network of physicians, people who

run healthcare institutions, people who run health plans, startup entrepreneurs, and policy wonks. We are seeing things that are so encouraging that it warranted a special report. A new shape for healthcare is emerging in a wide variety of new forms and models. What they have in common is that they have the capacity to actually drive healthcare to become not only better, but far less expensive than it is today. Yes, cheaper: Not just “bending the cost curve” to a lower level of medical inflation, but driving the cost downward.

Employers, as major customers of healthcare, and as buyers for other major customers (their employees) play a key role in this revolution. They have a far more intimate relationship with the customers than the other big buyers do, and they have a lot at stake, but they have a great deal more flexibility than health plans or government policy-makers. Finally, now, they are finding ways to use their market strength to force changes in healthcare.

This is not about rationing, or further waves of draconian reforms. It is about new possibilities springing up out of the private market’s response to the reform, and to other pressures of the time.

You’ve seen stage magicians. You know that when the stage magician pulls a rabbit out of his hat, there is no magic involved. It’s a real rabbit, and an ordinary hat. There’s a trick to it, it’s a trick you might not pick out no matter how many times you watch—but it’s a trick he could teach you to do, if you really wanted to learn. That’s what we are doing right here. There’s some homework first, then the rabbits. In these pages I will lay out:

1. **Where we are now:** The shape of the major challenges we are facing. The astonishingly large opportunity afforded by the waste, inefficiency, and disorganization of the traditional structures of healthcare.
2. **Economics 101 (and Healthcare Economics 101):** A brief refresher on core concepts that will show how we got here—and how we can measure ways out.
3. **The 5:** A five-part framework that is both necessary and sufficient for any organization to move forward.



4. **Next steps:** Resources. Strategy work. Evaluations. References. Study guides.

Along the way, I will note “Hats” (places that we might find rabbits) and “Rabbits” (real opportunities).

I am optimistic. In almost every healthcare gathering I am the most optimistic person in the room. I am an optimist because I can see a path out of the wilderness in which we are wandering. It is emerging from experiments and pilots all across healthcare. Each of the pieces is tested and has been shown to work. None of it requires any kind of rationing, and little of it requires political action. It is all possible within the system we have.

- Joe Flower



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Where We Are Now

What is happening to healthcare right now? How does that affect employers and employees?
Let's take a look.

Cost and the crisis of capacity

The reform drive was aimed at three things: cost, access, and quality. The reform act does a pretty good job at providing access to healthcare for all Americans, but it does little that is forceful and directive to drive down costs. Adding new people (and new covered needs) to the system will combine with other factors—demographics, the shifting insured base, the internal constraints of the industry—to drive up healthcare premiums and the actual costs of providing healthcare with surprising speed, over the next few years especially. This great rise in costs, and its shocking speed, will mean that cost is jumping to the fore as the single most pressing concern of patients, employers, health plans, health systems, and government.

At the same time, we are adding tens of millions of new people and new covered needs to the system, while doing nothing special to increase the capacity of the system to deal with them.

So the question of cost becomes very much a question of cost-effectiveness: How do we use the resources available as effectively and inexpensively as possible. This is the dominant question of the healthcare sector for the foreseeable future.

Trends

These two major crises are complicated by a range of other trends:

The reform act itself does little that is forceful to drive down costs.

Hat



Extreme cost pressures are making every part of healthcare more flexible and ready for experiment.

Where We Are Now

The Economy

We can expect the economy to improve, but jerkily, spasmodically and with wide regional variations. We can expect second and third dips over the coming few years. We cannot expect steady growth or anything like full employment throughout this decade. These bumps and twists will effect different regions and sectors of the economy differently, but the job market will be especially hard on the age cohort that is just pre-retirement.

Computerization and automation

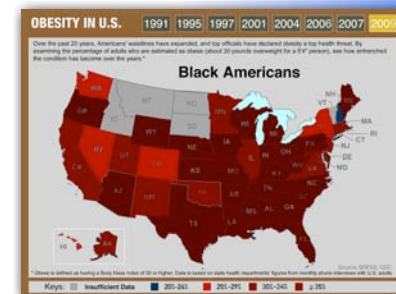
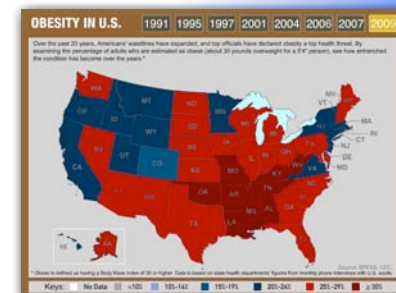
The sector will computerize and automate rapidly over this period, but the process will be more expensive and difficult than most people expect. The gap between the efficiencies that digitization could drive, and the understanding of how to drive it, both by healthcare providers and by IT vendors, remains wide and deep.

Chronic disease, prevention, maintenance

Chronic disease, which is estimated to be the root of some 75 percent of the costs of U.S. healthcare, is on a long upward trend. One marker of this future might be seen in the growth of obesity, with nearly a third of all Americans registering a body mass index higher than 30. In this small picture, the red states are those with more than 25 percent of the population with a BMI over 30. The dark red states have more than 30 percent.

This problem skews strongly against African-Americans. The second picture shows the African-American obesity profile. In the brown states, more than 35 percent of African-Americans have a body mass index over 30.¹

Finally, the problems posed by obesity and diabetes skew strongly against the Southeastern quadrant of our country. This map shows what I mean: See all those



¹ Centers for Disease Control and Prevention: Population Health Studies

Where We Are Now

dark counties in the south and east of the country? They are the counties that count in the top 40 percent for *both* obesity and diabetes. The scattered dark patches in other parts of the country are mostly counties that have a heavy Native American population.²

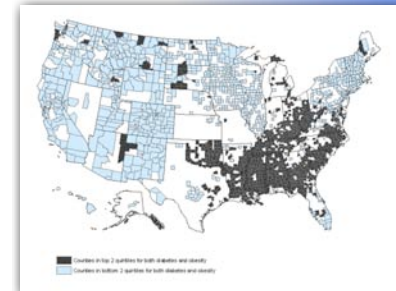
Our healthcare system is not set up to deal with chronic, maintenance, and preventive problems; both the payment system and the expectations of practice are set up to deal with acute episodes. We deal with chronic disease so poorly that it could almost be said that we do not deal with it at all. We need to direct far more attention and money into, for instance, programs to effectively manage such conditions as diabetes, congestive heart failure, asthma, COPD, alcoholism, and clinical depression. Cutting the cost and suffering associated with chronic disease by any significant fraction would make an enormous difference.

Boomers

The leading edge of the Baby Boom generation turns 65 this year. This massive cohort is beginning its long transition from the years of racquetball and kung fu through its years of Viagra and pacemakers, on the way to its years of walkers, hearing aids, and Depends. Their needs would swamp the system even without the rise in chronic disease.

Aging clinical workforce

But Boomers make up as big a chunk of the clinical workforce as they do of the healthcare market. Just when tens of millions of Boomers will be entering their peak years of needing diabetes care and cardiovascular care, many of the endocrinologists, cardiac surgeons, and other clinicians that they need will be ready to retire. Already, surveys show that more than half



Hat



There are huge costs in chronic disease—and so huge opportunities in controlling it.

² Centers for Disease Control and Prevention: Division of Diabetes Translation, National Diabetes Surveillance System. Available at: <http://www.cdc.gov/diabetes/statistics>

Where We Are Now

of all physicians plan to cut back on patients, cut back on hours, or get out of the field altogether within the next few years.³ A quarter of the RNs in the U.S. are already out of the field, while another quarter are planning career moves in the short term that will take them away from direct patient care.

Aging patients, aging workforce, rising chronic disease, steeply rising cost: All of these point to a vast and increasing need for some kind of new efficiency and effectiveness in the way we provide healthcare. And that crying need is sharpened by the increasing awareness that we could do healthcare for less—much less.

Changes in the insurance market

The reform act is bringing tens of millions of new people into the healthcare system, widening the covered conditions, and mandating that all preventive and maintenance care be covered from the first dollar.

At the same time, the pace at which consumers are switching to high-deductible “consumer-directed health plans” is accelerating, and can be expected to continue to accelerate until such plans dominate the market. Based on current experience, such insurance customers, with more “skin in the game,” can be expected to act much more like “consumers,” seeking out value and comparing costs, and being much more active in deciding what medical care to access, where, when, by whom, and how paid for.

**We could do
healthcare for
less—much less.**

Waste

A good rule of thumb in systems thinking says that the solutions inevitably lie in the problems themselves. In the face of all this extraordinary chaos

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Employees who act like smart consumers can actually drive changes in healthcare.

³ “The Physicians’ Perspective: Medical Practice in 2008” Report on a survey by Merritt Hawkins & Associates for The Physicians’ Foundation, October, 2008

Where We Are Now

and uncertainty, one factor shows special promise. It is a problem so large that its solution could solve all other problems. That is the problem of waste. Healthcare in the United States is done with such astonishing inefficiency, maldistribution, and waste that it turns out to be an extremely useful question to ask whether we could actually do it better, for everyone, for less money than we now spend—and to ask whether any mechanisms exist (or could be imagined) that would get us there.

We could, in fact, do healthcare for less. How much less? Ten percent less? Twenty percent? Thirty percent? How about 50 percent?

We could do healthcare for half of what it costs today.

We could do healthcare, at markedly higher quality, for everyone in this country, without rationing or denying anybody the care that they need, without having the government dictate how doctors practice or whether hospitals could expand, at half the cost we do it now.

This is not so much a prediction, or even a goal. Exactly what “half as much” would mean 10 or more years from now is not clear, since in that time both the population and the economy as a whole will grow, there will be inflation, and other factors that render such a prediction mushy to the point of meaninglessness. It is, instead, an expression of the enormous size of the opportunity. It was only 12 years ago that we spent half as much in dollars per capita on healthcare as we do today. It was only 30 years ago that we spent half the percentage of GDP as we do today.⁴ There is nothing inevitable or absolute about the idea that we have to spend 17.5 percent of GDP, and upwards of \$8400 per person per year on healthcare, and that these figures simply must increase year after year. Other basic sectors of the economy supporting basic human needs, such as food, shelter, and clothing, have steadily shrunk the percentage of GDP and of the average person’s budget, over the decades.

We could do healthcare for half of what it costs today.

Hat



The size of the waste in healthcare means that the opportunity is vast, for anybody who pays for healthcare.

⁴ OECD Health Data 2010, accessed at www.ecosante.org/oecd.htm October 28, 2010

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The remarkable thing about this assertion is that most of the economists, statisticians, and policy experts who most deeply study healthcare in the United States would not find it remarkable at all. They would argue how we got here and how we could get out of it, but the idea that theoretically we could do healthcare for half as much would not be that controversial.

Why would I make such an assertion? Where is the evidence to back it up?

The most obvious evidence is the experience of other countries: All other advanced economies render healthcare to all their citizens for half (at most two thirds) of what we do, whether measured per capita or as a percentage of the national output, and they have better health outcomes. In other words, they get more for less than we do.

In the public conversation, on talk shows and at parties and in online forums, people immediately ask the obvious question: “What are we spending so much more on?” They all have their favorite answers: Malpractice, the profits and overhead of insurance companies and drug companies, greedy doctors, wasteful government bureaucrats, lazy and unhealthy patients, answers that spring from their particular political worldview or their experience. It’s like a Rorschach inkblot test.

But there is a real answer to the question, “What are we spending so much more on?” The real answer is: Everything. A number of careful, thoughtful analyses that compare U.S. healthcare spending to that of other wealthy countries come to the same conclusion: We pay more across the board. We pay more for each drug—and we buy more expensive kinds of drugs, and more of them. We pay our doctors and nurses more, and each of us on average uses them more. We also use our clinicians far less efficiently, with many doctors spending inordinate amount of time on non-productive tasks such as arguing with insurance companies and filling out forms to comply with HIPAA and other measurement regimes. We pay more for inpatient care, and for outpatient care. Administrative expenses for insurance are higher than other countries with private insurance because of our highly fractured system, but even our public program expenses are higher than theirs. We spend far more on public health and prevention (public health departments, community health centers, the FDA and the CDC),

**What do we
spend more on?
Everything.**

Where We Are Now

research, and medical facilities. Compared to the size of our economy, we spend substantially more on every category of healthcare except long-term care, home care, and durable medical equipment than every other OECD country.⁵

But “paying more” does not necessarily mean “waste.” Perhaps it is reasonable that we spend more for some things. We certainly want to be preeminent in medical research, and maybe we insist on more access, and more choice, than say citizens of the U.K. have. But what is more telling, more instructive, what might actually lead us to some thoughts about how to spend less, is a different set of statistics: The variation in costs within our own borders, variation that is not matched by sicker people in one place than another, or richer people, or different state regulations, or any other obvious factor—or by better outcomes. In some parts of the country we pay much more for healthcare per person than in other parts, and get no more health in return. As any quality engineer will tell you, when you see variation for no reason within a system, you’ve got a problem—and an opportunity for improvement.

The variation in costs within our own borders is huge: It typically costs Medicare 60% more (per patient per year) for patients treated in places like Miami, Los Angeles, New York, Boston, or McAllen, Texas, than if you are treated in places like the San Francisco Bay Area, Seattle, Minnesota, or northeastern Pennsylvania.⁶ The growth rate of Medicare spending over the last two decades has been wildly different in different hospital referral regions. Between

The variation in costs is huge.

⁵ U Reinhardt, P Hussey, Anderson, “U.S. Health Care Spending In An International Context: Why is U.S. spending so high, and can we afford it?” *Health Affairs*, May/June 2004
D Farrell *et al*, “Accounting For The Cost of U.S. Healthcare: A New Look at Why Americans Spend More,” McKinsey Global Institute, December 2008

⁶ A Gawande, “The Cost Conundrum: What a Texas town can teach us about healthcare,” *The New Yorker*, June 1, 2009

B Sirovich, P Gallagher, D Wennberg, E Fisher. “Discretionary Decision Making By Primary Care Physicians And The Cost Of U.S. Healthcare,” *Health Affairs*, 27, no. 3 (2008): 813–823

E Fisher *et al.*, “The Implications of Regional Variations in Medicare Spending,” *Annals of Internal Medicine* 138, no. 4 (2003): 273-298

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1992 and 2006, Medicare spending per person grew twice as fast in some places than others.⁷

This variation does not correlate with socioeconomic status, education, or race. The San Francisco Bay Area and Seattle, for instance, are among the better off parts of the country, while McAllen, Texas is one of the poorer spots. In fact, every year Medicare pays more on average per recipient in McAllen area than the average working person there earns.⁸ The variation correlates only with how many medical resources there are in an area—how many specialists, ICU beds, and scanners there are per capita—and in the readiness of physicians to use those resources. One Dartmouth Group study found that, in cases where the supporting evidence was strong, doctors in the high- and low-cost areas were equally likely to recommend specific, standard interventions. But in the grey areas, they acted differently. They were much more likely, for instance, to send someone with typical gastroesophageal reflux or stable angina to a subspecialist. For an 85-year-old with an exacerbation of end-stage congestive heart failure, they were much more likely to admit the patient to the hospital, three times more likely to admit directly to the ICU, and 30 percent less likely to discuss palliative care with the patient or the family.⁹

And the people in the more costly areas are no better off. As Atul Gawande, the Harvard surgeon and *New Yorker* writer has noted, “To make matters worse, high-cost communities appear to do the low-cost, low-profit stuff—like providing preventive care measures, hospice for the dying, and ready access to a primary care doctor—less consistently for their patients. The patients get more stuff, but not necessarily more of what they need.”¹⁰ In fact, the only

Medicare Growth Rates 1992-2006	
Dallas	5.3%
Miami	5.0%
Charlotte	4.7%
Washington, D.C.	2.5%
San Francisco	2.4%
Pittsburgh	2.3%
Atlanta	2.3%

⁷ E Fisher, J Bynum, J Skinner, “Slowing the Growth of Health Care Costs—Lessons from Regional Variation,” NEJM 360;9 2/26/09 849-852

⁸ A Gawande, remarks, “How Do They Do That?” conference, Institute for Healthcare Improvement, July 21, 2009

⁹ E Fisher, J Bynum, J Skinner, *ibid*.

¹⁰ A Gawande, remarks, “How Do They Do That?” conference, Institute for Healthcare Improvement, July 21, 2009

Where We Are Now

visible variations in outcomes is negative: every procedure has a risk, and when you do more of them, more people die, an estimated 30,000 per year.¹¹

In our own country, some people get significantly better care for significantly less money.

A striking example arose from a 2008 Dartmouth Healthcare Group study that compared what it cost to be treated in the last two years of life at different medical centers. The high-end examples were not surprising—Cedars-Sinai and UCLA in Southern California, and New York University Medical Center, all premier institutions offering the best healthcare money can buy. What was surprising was the low end. Among major medical institutions, the least expensive were the Mayo Clinic and the Cleveland Clinic—also premier institutions offering the best healthcare money can buy. **How can the best healthcare money can buy cost half as much as the best healthcare money can buy?** When, in aggregate, you get the same high-quality product for half the price, the difference in cost can reasonably be characterized as waste.¹²

This is actually the good news. The fact that there are places that cost much less means that there are models right in our own country, in the existing system, that show how to do it better for less. And those models show that it is possible to ignite a “virtuous spiral” which will progressively drive down costs and give better care at the same time.

This is actually the good news. It means there are models right here.

A wide range of studies identify huge amounts of waste in U.S. healthcare—most of it leading to worse care, not better. Thomson Reuters released a large meta-analysis of a number of these studies in the fall of 2009. The aggregate of the studies identifies \$600-\$850 billion in waste per year— $\frac{1}{4}$ to $\frac{1}{3}$ of the entire amount that we spend on healthcare.¹³

¹¹ S Brownlee, *Overtreated: Why Too Much Medicine Is Making Us Sicker And Poorer* (Bloomsbury 2007), estimate from Elliott Fisher, MD, of the Dartmouth Group on Healthcare, p. 36

¹² R Pear, “Researchers Find Huge Variations In End-Of-Life Treatment,” *New York Times*, April 7, 2008

¹³ R Kelley, “Where Can \$700 Billion In Waste Be Cut Annually From The U.S. Healthcare System?” Thomson Reuters White Paper, October 2009

Where We Are Now

Asked in confidential surveys, nearly all U.S. physicians admit that they practice “defensive medicine” and “assurance medicine.” Collectively, they estimate that roughly 30 percent of the tests, images, and other care they render is unnecessary and inappropriate, rendered either out of fear of malpractice suits, or out of a desire not to lose the patient to another doctor who would, for instance, prescribe an antibiotic for a cold, or order an MRI for a hard-tissue knee problem.¹⁴

If somehow the whole country emulated the way medicine is performed in the less expensive areas, the cost of U.S. healthcare would drop by approximately 30 percent.

Finally, these differences—between the U.S. and other countries, and between different parts of the U.S.—only measure the way we do healthcare now. They do not take into account any of the myriad ways in which healthcare could be made more efficient and effective. Taking all this into account, it is easy to imagine that we could drop the cost not just by 30 percent, but by 50 percent or more, while giving better care to all Americans.

So the waste, inefficiency, and maldistribution are definitely there, at massive levels. But how could healthcare become more efficient? What mechanisms are there that would drive healthcare to do its job better, for more people, for substantially less money? What can employers do to help drive it there?

To get to that, we have to examine some fundamental economic ideas.

We could drop the cost by 50 percent or more, while giving better care to all Americans.

¹⁴ “Waste and inefficiency in the U.S. healthcare system, Clinical Care: A comprehensive analysis in support of system-wide improvements” New England Healthcare Institute, February 2008
“Health reform’s taboo topic: Defensive medicine,” Washington Post, July 31, 2009

Economics 101 (and Healthcare Economics 101)

How did we get in this mess? How do we end up paying so much for health care and not getting what we want?

It's a big question, and it's at the core of the mess we are in. The convoluted way we pay for health care in the United States gives too many patients treatments that they don't need, or treats them for conditions that could have been prevented with much cheaper care, or denies patients services that they actually need. How does this happen?

To answer this question, we have to dig into the actual structures of health care, and some of the basics of economics. And in that answer we can begin to see how we need to rebuild those very structures in order to survive and thrive beyond reform.

Why Doesn't Competition Seem to Work in Health Care?

There certainly seems to be plenty of competition. For example, there are:

- thousands of hospitals of all different types (for-profit and nonprofit, free-standing and chain, general and specialty, teaching, children's, public and private, military and veterans);
- hundreds of thousands of doctors in scores of specialties organized every way you could imagine (solo practice, small practice, large multispecialty practice, working for hospitals and health systems, running their own centers, or in cooperatives like Group Health of Puget Sound and staff-model HMOs like Kaiser);
- hundreds of health insurers;
- scores of pharmaceutical companies, device manufacturers and other health care vendors supplying bed pans, gurneys and ambulances; and
- thousands of pharmacy benefit managers, vendor certification companies, disease management agencies, consultants and other companies providing bits of outsourced management expertise.

Economics 101

Though there is plenty of regulation, on most levels of the system there is no central Soviet-style commission allocating resources and deciding who gets which customers. All these organizations are free to compete for the customers' dollars.

Why, with all that competition, can't most of us seem to get the care we need when we need it, where we need it, at a reasonable price? For most Americans, though we can see that modern medicine offers a nearly miraculous plethora of cures and therapies, our access to it through the care industry is often arbitrary, often so arbitrary as to be cruel. For those under 65, the price is often so high that even insured people can be one serious disease or traffic accident away from permanent poverty. And even when it works, it can be mind-blowingly inconvenient.

How can that be? How can a "free market" system so blatantly fail to serve its customers? Until we find the answer to that question, we will never be able to find our way out of this mess.

Let's do a little basic analysis, a little Economics 101.

How can a "free market" system so blatantly fail to serve its customers?

The Value Test

Every time you buy a shirt, a latte, or a stock, you ask a series of questions: "How good is this thing? How do I know? How much will it cost? To be specific, how much will it cost me? How much it will it cost me, really? How much will the whole thing cost me? What are my alternatives?" Under our usual business models and payment structures, and without any way to get real information, most of those questions are unanswerable in healthcare. We have few real measures of value, few real prices, and little opportunity to even find out what "the whole thing" we are buying is. And the most common "alternative" is doing nothing.

As healthcare costs rise, more and more of healthcare's customers (from individual consumers to employers, insurance companies, and government payers) are seeking ways to ask and answer these fundamental questions:

Hat



There is a big payoff for employers in driving healthcare organizations toward providing real value.

How good is this? What does it cost? What are the alternatives? They will be increasingly basing their “buy decisions” on finding satisfactory answers to those questions. So organizations in healthcare that can answer those questions clearly and satisfactorily will survive and thrive; those who cannot will fail.

What does the customer want?

Health care is a business. Health care is the biggest business in the U.S., which is to say it is the biggest single business sector in the history of our species. Every business has customers.

Some people object to calling health care a “business.” They want to think of it as a “service.” Many parts of healthcare are not-for-profit. But to really thrive, every business, for profit or not, must think of itself as a service; and every service must think of itself as a business. It must think: Who are our customers? What do they want?

What do you want, as a customer of healthcare? I want four things:

1. When I am sick, fix me.
2. If you can't fix me, help me manage it.
3. When I am not sick, help me stay well.
4. Be there when I really need you.

In general, healthcare is really good at the last of these. It's there when we need it. That's why our Emergency Departments are overflowing. The other three have far more spotty results.

If I am not getting what I want, chances are it's because I am not the true customer. Those providing the services don't really see me as the customer. Who is the customer?

What's a customer? Customers decide that they want something, choose it and pay for it. You decide that a new TV would be nice. You look online, maybe, or go to a big-box store, maybe

Economics 101

check out some local independent store. You find what seems a reasonable value for your money, and you plunk down the credit card. You're a customer.

The customer is the key regulating part of any market economy. The customer is the reason you never see either a plate of scrambled eggs or a new car advertised for \$1,000. It's the customer that enforces all sense of value.

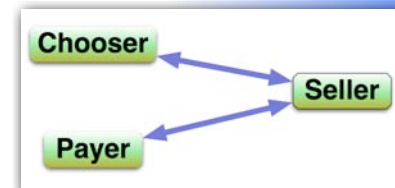
So what's different between classic economics and health care economics? Classic economics pictures a buyer and a seller. There is a constant, dynamic feedback loop between the many buyers and the many sellers in a market that establishes not only what things cost, but even what's offered for sale, and on what kind of terms.



Economics starts with this image of a marketplace: There are buyers and sellers, and some flow of information between them. They haggle, and a "market price" arises out of that continuing dynamic.

The core driver of all health care economics is the utilization decision, that is, people deciding to make use of some health care service. They get a new hip, take a new drug, get an exam, go in for a mammogram. The great majority of health care is insurance-supported, whether through government insurance such as Medicare, or through employers' private insurance. And the great majority of health care is provided fee-for-service, that is, the health care provider (the doctor or hospital) bills the insurance payer for each separate test, procedure or prescription.

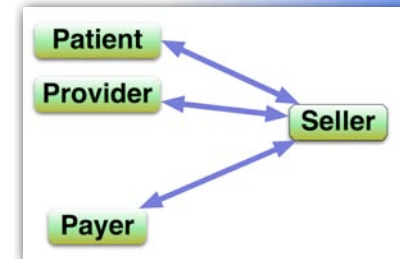
So what happens to that feedback loop in insurance-supported, fee-for-service healthcare? First of all, the buyer is split in two, into a chooser and a payer. The organization that pays the bill does not make the decision to use that particular service. So the feedback loop between buyer and seller is obscured. And the chooser and the payer have quite different agendas. If the payer is just there to pay, it can have only one goal: to pay as little as it can get away with. It might set rules



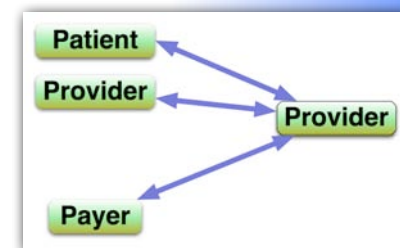
Economics 101

and payment schedules, but can never quite get it right, since it is really not there in the transaction, making the choice.

It gets even less clear: Who is the chooser? Who is deciding to use the service? Again there's a split. The chooser is not the patient alone, but the patient (or the patient's family) in consultation with the provider (usually the doctor). So again, and in a different way, the buyer is split. And the patient and the provider have very different stances. The patients have enormous "skin in the game"—great incentive to use whatever services might seem to help, since it's the patients' body, their pain, indeed often their life or death, that is on the line. The provider, on the other hand, has almost all the resources: the knowledge, expertise, equipment and access to drugs and therapies. And in any given transaction, the provider has far less skin in the game: this patient is one of hundreds or thousands. So the feedback loop gets even more obscured and tortuous.



It grows yet more murky: Who is the "seller?" Who is providing the service that is being sold? In most instances, it is the provider. The doctor who is advising the patient on buying the service is often either providing the service or working for the organization that will provide the service—or even owns it. You need a new knee. But you're in luck, you've come to the right place, because I am an expert knee-installer. And the seller, of course, has a completely different agenda from the buyer. Any seller's agenda is simply to sell as much as possible. So the feedback loop between buyer and seller becomes so tortuous and knotted as to be useless, and the system skews, as a normal part of doing business, toward selling the services that make the most money, and that get the seller in the least trouble.



Out of this we get markets in which, for instance, it can be very hard for a Medicaid recipient with diabetes to get (or even hear about) the nutritional counseling that might help her save her feet, but quite easy to get a surgeon to amputate her feet when her diabetes destroys them.

What Are Health Care Providers Paid To Do?

This may sound overly cynical. Many doctors would protest that they never offer a service just because it would make them more money. But, as one neurologist put it to me: “The more I care about my work, the less money I make. The way for me to make more money is to serve my patients less: Give them less time and attention, and cut them loose as soon as possible.” That’s a terrible bind to put our best medical minds in. Many doctors doubtless choose the path this doctor does: Do better work and make less money. But many doctors feel forced to make the other choice: Do poorer work and make more money. This is scandalous. Any improved system of healthcare has to find a way to compensate doctors well and fairly for doing the best work they know how to do.

It is important to remember the two core rules of economics:

1. People do what they are paid to do.
2. People do *exactly* what they are paid to do.

People notice in exquisite detail what makes them money and brings them success. They will not as a normal practice do things that cost them money, or put them at risk of getting in trouble. In health care, what brings a provider money and success is doing more of the procedures and tests that are well-compensated by payers, and doing less or none of the ones that are not well-compensated—and certainly never failing to do some test or procedure that might keep them out of a malpractice suit, whether the patient really needs it or not. And those well-compensated and malpractice-safe procedures and tests are only indirectly related to the four things we really want when we think we are the customer. Almost no one in health care is directly paid to give us what we actually want.

This is the core reason why the economics of non-integrated, fee-for-service medicine run counter to the expectations of classic economics in one crucial respect: Supply pushes

Hat



Finding ways to pay doctors to do what we actually want them to do straightens out a number of the economic feedback loops in healthcare.

demand. Patients in the high-spending areas are not getting charged more per service; they are getting more services—more visits to specialists, more time in the ICU, more tests, more images—with no better results.

The core driver

The core driver of this revolutionary change emerging in healthcare is that the sector is getting clearer about who its customers are, and what they need and want and demand—largely because the customers are getting clearer and more demanding. They did not use to see themselves as “customers.” Now increasingly they do, with all that implies, and that will make all the difference. Individual consumers, because of high-deductible plans that give them more “skin in the game,” are much more inclined to question the value of any given expense. Employers are increasingly seeing that they can drive down costs by getting deeply involved in the health of their employees. And health plans, deprived of many of the “risk management” techniques that were core to their business models, are increasingly seeking other ways to differentiate themselves in the marketplace by bringing real value to their customers.

Who, finally, is the “customer” of health care? That’s still complex. Obviously the ultimate customer of health care is the individual with a human body—the employee, the patient, the rate payer, the citizen. But there are many proximate customers representing the individual—employers, health insurers, state and federal governments. And for many parts of health care, the proximate customer is some other part of health care. What is driving the revolution is that the major customers of health care—individuals, employers, insurers, and governments—are coalescing on the same set of desires: They want health care that works, that costs less, and that is accountable. And they are willing to pick and choose to get it, even willing to set up whole new business structures and payment systems to get it.

What the customer wants, the customer will get, one way or another. Though these emerging forces may take years to work their way through the healthcare marketplace, in the end, they

**Who, finally, is
the “customer”
of healthcare?**

will prevail, and reshape the entire sector. Any healthcare organization that wishes to survive must figure out how to provide:

1. Healthcare that works, that provides the outcomes that the customers want
2. Healthcare that costs less, not just less per item, but less overall—a lot less
3. Healthcare that is accountable, that is truly measurable by the yardsticks that customers choose, and truly transparent

How do employers drive healthcare organizations to provide that? In this new climate, employers can get better healthcare for less money if they excel at five interdependent imperatives.

The 5: A Framework

1: Employee health? Put a crew on it

Chronic disease, prevention, behavior, maintenance: This is the big piece. It's time to put a crew on it.

If you want to make healthcare work for you—if you want to cut your medical costs, cut absenteeism, disability, and medical early retirement, while improving your employees' health and easing their suffering from disease—you have to go to where most of the costs are generated and most of the suffering lives. You have to face up to chronic disease.

Most of your healthcare costs, as an employer, come from chronic disease. Various studies estimate that some 70 to 75 percent of all healthcare costs in the United States come from chronic disease. That's huge.

We are dropping the ball on chronic care in an unbelievable way.

Think about diabetes, a devastating disease that is growing by leaps and bounds across our country. Imagine someone who develops the disease. How long do you think it takes for them to get a diagnosis, to hear “You have diabetes,” so that they can start dealing with it? On average, 10 to 12 years. And how many of those people get any follow-up at all? Fewer than 40 percent. No wonder we are failing at it.

This is despite the fact that study after study shows that, when it comes to investing in the health of employees, the return on investment (ROI) is almost always positive—to society, to the healthcare system, and to the employer—even counting just direct medical costs. Counting the “externalities,” such as lost productivity and absenteeism, the return is huge.

Yet people don't tend to see it that way:

Hat



Big opportunities typically live inside big problems. It's their natural habitat. Chronic disease is a huge problem.

The 5: A Framework

- **Patients** don't believe chronic disease is a problem until it hits them over the head.
- **Healthcare providers** are typically not paid (or not paid much) for prevention—and frankly, paid the way they are today, to be really good at prevention would be a health-care miracle but a business disaster, depriving providers of much of their income.
- **Employers** have wrongly believed that the ROI is negative for them, and that it is not a workforce problem, and have been unwilling to pay.
- **Health plans** have until recently remained skeptical that it is a good investment for them—despite pilots that have shown low-hanging returns of some 300 percent per year.¹⁵

It's not a job we are doing poorly—it's a job we are not doing. We need to direct far more attention and money into effectively preventing and managing such conditions as diabetes, congestive heart failure, asthma, congestive obstructive pulmonary disorder (COPD), alcoholism, and clinical depression. Cutting the cost and suffering associated with chronic disease by any significant fraction would make an enormous difference—both for your employees and for you as an employer.

**It's not a job
we're doing
poorly. It's a job
we're not doing.**

We can do this. Steve Burd, the CEO of Safeway, told Dean Ornish: "There's no question that this problem is going to get solved if we address the root causes. Rarely in a lifetime does a problem this big, this complex, surface that you can sit around a water cooler and say: you know, we can solve this one. Prevention and behavior matter. They are the Holy Grail of a healthcare solution."

¹⁵ Gold and Kongstvedt reported these figures of Blue Cross/Blue Shield of Minnesota in *Managed Care*, November 2003

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What's the return?

What's the return on investing in promoting your employees' health? Every time someone tries to answer that question, they come up with eye-popping numbers. The lowest number we ran across in any of the studies was \$1.49 for every dollar invested. The highest was an amazing \$13. The average was around \$4.¹⁶

Employees with chronic health problems cost you money. One health plan, for instance, ran the numbers on its own employees. As part of their voluntary program for improving their health, it catalogued their health "issues," such as high cholesterol, asthma, overweight, or high blood glucose. People who had one such issue cost the company's self-funded health plan an average \$2693 per year; those with three cost \$3969; those with five cost \$5108—and those who didn't sign up for the program cost \$5,503, more than twice as much as those with no issues at all.¹⁷

Besides the immediate, quantifiable reductions in medical costs, other studies show all kinds of other benefits from getting involved in your employees' health—greater productivity,

Healthier employees are smarter, more productive—and there at work.

¹⁶ Goetzel RZ, Juday TR, Ozminkowski RJ. AWHP's *Worksite Health*, Summer, 1999. A meta-analysis of 24 economic analyses of health and productivity management programs. Average return: \$3.14 per \$1 invested in traditional health promotion programs. The ROI estimates for the individual programs ranged from \$1.49 to \$13.

Aldana SG. *American Journal of Health Promotion* 2001; 15(5) – 296-320. Aldana reviewed 72 articles. Average ROI: \$3.48 for health care costs alone, \$5.82 per \$1 including absenteeism.

Ozminkowski RJ, Dunn RL, Goetzel RZ, Cantor RI, Murnane J, Harrison M. *American Journal of Health Promotion* 1999; 14(1) – 31-43. A 38-month case study of 23,000 participants in Citibank's health management program. ROI: from \$4.56 to \$4.73.

Chapman LS. Specialist opinions on "best practices" in employee health promotion (WHP). the *Art of Health Promotion Newsletter*, July/August 2004. meta-evaluation of 42 studies. ROI reported: \$2.05 to \$4.64

¹⁷ M Ridley, D Johnson MD, Premera presentation, World Health Congress, February 1, 2010

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intellectual capacity, and reductions in disability¹⁸ and absenteeism.¹⁹ So you not only get healthier employees and lower medical costs, you get smarter, more productive employees who are there more often.

Getting really involved

These numbers are for health *promotion*, such as providing employees with diabetes screenings. The returns are huge because the costs are low, and they take a direct shot at the easiest targets. If a little information can get even a few high-risk employees to get their blood sugar looked at, or begin taking a statin for their hypertension, you get a huge return on that small investment.

But can you scale that up? What's the next level? What can you do that doesn't just give a big return on a small investment, but actually lowers your overall healthcare costs by a substantial amount?

To lower your healthcare costs and improve your bottom line, you have to go beyond health *promotion* to health *intervention*.

Much, if not most, chronic disease springs from our behavior: what we eat, how we exercise, how much we drink and when, how well we sleep, how we deal with stress. The conventional wisdom has always said that while you can put out diet books and open exercise salons, on a mass scale you really can't do much about people's behavior, diets, and habits.

Conventional wisdom is just wrong.

Recent experience shows that conventional wisdom is wrong. Direct, targeted intervention in chronic health problems can have impressive effects. Consider, for instance, the signal suc-

¹⁸ Serxner S, Gold D, Anderson D, Williams D. *J Occup Environ Med*. 2001; 43(1) – 25-29.

¹⁹ Aldana SG. *American Journal of Health Promotion* 2001; 15(5) – 296-320
Riedel JE, Lynch W, Baase C, Hymel P, Peterson KW. *American Journal of Health Promotion* 2001; 15(3) – 167-191.
Edington MD, Karjalainen T, Hirschland D, Edington DW. *AAOHN J*. 2002 Jan; 50(1) – 26-31
Aldana SG, Pronk NP. *J Occup Environ Med*. 2001 Jan; 43(1) – 36-46

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cess of Kaiser of Northern California with heart attacks. A team of Kaiser clinicians asked themselves what it would take to seriously reduce the number and severity of acute myocardial infarctions (AMIs, or “heart attacks”). They put together a coordinated team effort. It worked. Over the past decade the number of heart attacks among Kaiser members has dropped by 24 percent—62 percent for serious heart attacks requiring immediate surgery and hospitalization.²⁰

Other experiments and programs have shown similar success in a variety of contexts. Think about these, and what they might have to teach your organization.

Boeing gets intensive

Employers are realizing that they can save money by improving the health of their employees, and are getting aggressive in finding ways to do that.

Take, for instance, Boeing’s experience. In the spring of 2010, Boeing announced the results of a 30-month trial of an “Outpatient Intensive Care Program” in which 750 employees with multiple chronic conditions were given intensive personal attention from multi-disciplinary clinician teams to help them manage their disease. Boeing has a lot of high-value employees, especially hard-to-replace aircraft engineers. The company is concerned not only with medical costs, but with turnover, disability, productivity, and absenteeism. Boeing is self-insured (with the plan managed by Regence Blue Cross Blue Shield), so any improvements in cost drop straight to the bottom line.

The experiment was a collaboration between Boeing, Regence, and several major healthcare providers in the Seattle area, mostly multi-specialty practices that Boeing had worked with before. The test compared the 750 participants with a control group of 750 with similar health profile and the usual access to healthcare who declined to participate.

**Twenty percent
cost reduction on
“frequent fliers”**

²⁰ Yeh *et al.*, Population Trends in the Incidence and Outcomes of Acute Myocardial Infarction, NEJM Volume 362:2155-2165 June 10, 2010, Number 23

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Over the 30 months, even counting the cost of the clinician teams and all the extra attention, the intensive effort saved 20 percent of their healthcare costs.²¹

Twenty percent cost reduction on “frequent fliers” with multiple conditions is a big result. And by the way, the employees who volunteered for the program had a higher opinion of the company because of the program—but so did the employees who declined to participate.

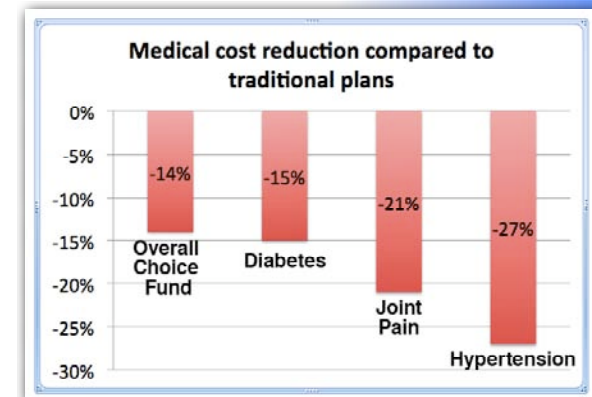
Such a success does not go unnoticed. As experiences and results like Boeing’s become better known among large employers, we will see many more examples like this.

CIGNA and Safeway go all-in

Every year-end for several years now CIGNA has released the results of participation in their “Choice Fund” consumer-directed health plan (CDHP). In January of 2010, for instance, CIGNA reported that employees enrolled in the CIGNA Choice Fund, compared with those enrolled in their more traditional plans, had 14 percent lower medical costs. People with specific chronic conditions did even better—15 percent lower for diabetes patients, 21 percent lower for people with joint and back pain, and 27 percent lower for people with high blood pressure. And this is key: The employees did not save money by skipping medical care. People on both types of plans were equally compliant with treatment regimens. The difference in cost seems to spring from better management of chronic conditions, and more careful use of preference-sensitive services.

The business press regularly reports CIGNA’s results as proof that CDHPs lower healthcare costs and improve employees’ health—but that’s getting the story wrong. The CDHP alone is not what works. What works is using the employees’ “skin in the game” as the basis for a comprehensive program of incentives and massive clinical and informa-

Twenty-seven percent cost reduction for people with high blood pressure



²¹ “Boeing health care pilot project cut costs 20 percent – and improved care,” Puget Sound Business Journal, April 23, 2010

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tion support aimed at behavior change, education, preventive measures, and control of chronic syndromes. The programs vary from market to market, even from one employer to another, and often involve contracts with specific health-care providers to deal with specific types of problems. Employers pay a small amount extra per year for the extra support, expecting that they will be able to recoup the extra payment in lower costs over time.

CIGNA's star example is Safeway, a large employer with a very different employee profile from Boeing. Safeway started working with CIGNA to drive down its costs in 2004. Before then, its healthcare costs were rising by 10 percent per year. Since then, they have been flat, over a period when everyone else's costs rose by 40 percent. The first year, 45 percent of eligible employees signed up. After the first year, Safeway rewarded its employees by a premium *reduction* of 25 to 34 percent, and 71 percent signed up. Nearly 80 percent of the employees in the program rate it good, very good, or excellent.²²

Where in this whole healthcare debate have you heard of actual, substantial reductions in health premiums? What's interesting and provocative is that the rough shape of the CIGNA program is not all that different from the Boeing experiment: A malleable, intensive, ad-hoc partnership between providers, employers, and a health plan, aimed at driving down the costs of health care for specific employee populations.

Keeping score

Here's a key part of the Safeway story: CIGNA had the ability to drill down into the claims data to see exactly what was going on, and to see how things changed as Safeway changed the rules and incentives. eSync, a proprietary software offered by OptumHealth, does similar duty. Whether your organization insures with OptumHealth's parent company UnitedHealth Group or someone else, or whether you self insure, you can use

Rabbit



By changing the structure of their benefits and giving them good information and resources, you can influence your employees both to become healthier, and to make more sensible, cost-effective choices about their healthcare..

²² "Mr. Burd Goes to Washington," *Wall Street Journal*, June 19, 2009

D Ornish, "Why Health Insurance Doesn't Work," *Newsweek*, May 15, 2009

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eSync to watch the impact of any of your health initiatives in real time, as it is happening.²³

Why the employer?

It's an historical accident that employers ended up in charge of funding healthcare for their employees. It largely started in World War II, when employers ramping up for war production were suddenly desperate for workers, but the government had imposed wage caps. The only way to compete for workers was to offer better benefits, especially healthcare. After the war, unions pushed to keep and expand those benefits, and employers (even those with non-union workforces) continued to see them as a way to get and keep good workers.

By 2009, the burden of healthcare had become so great that many employers hoped that reform would take the burden away. Instead, reform made the burden mandatory, so employers have become even more desperate to find a real solution.

But there's the rabbit in the hat: Most healthcare costs are due to chronic disease, which means that we can drop the costs by influencing how people behave and what choices they make. Study after study has shown that you can only influence people's behavior and choices if you are close to them, if you speak their language, if they are in a group that is being similarly influenced, and if you have some control over their incentives. Who has that level of intimacy with masses of people? Not the government. Not policy wonks. But employers can. Employers can shape the work environment, can shape the incentives, can shape the culture at work. They can change their employees behavior and choices, and everyone comes out ahead.

²³ Company information, April 6, 2009

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2. Share risk

In any system, risk is as important as cost. In fact, risk drives cost.

The core idea of financial risk is simple: If you make the “wrong” choice in the system, does it cost you money? If you make the “right” choice, do you get to keep more money?

In healthcare, more obviously than in other things, the financial risk of the moment is balanced against personal risk: If I skip going to the doctor because it will cost me money, will this problem turn into something serious? And will that cost me a lot more money?

The right balance of risk is the life or death of any economic system. In traditional full-benefit health insurance, the balance is way off. The “buy” decision in healthcare is the utilization decision, the decision to use or not use some part of the system. Who makes that decision? The patient and the doctor. Or the patient’s caregiver or family, with the doctor or someone else working for a healthcare provider. Who is at risk for that decision? The health plan or the employer, which ultimately means the employer, as the health plan raises rates to compensate. If the patient makes a “wrong” choice and decides, say, to have an unnecessary surgery, it costs her no money. If the doctor makes the “wrong” choice, to perform the unnecessary surgery, it does not cost her any money. In fact, the doctor (and the hospital and the anesthesiologist, and the imaging center, and the rehab center) actually make more money. And in this traditional, full-benefit traditional scenario, if they screw up and the patient develops an infection and comes back to the hospital, or the surgery has to be re-done, they make even more money. The risk is completely backward.

The problem of risk illustrates why **none of the grand schemes for fixing healthcare would actually work**, unless they were carefully counter-balanced with an array of risk-sharing details. The traditional system has dumped all the risk on employers or, for Medicare, on the

Hat



The balance of risk in traditional healthcare is so cock-eyed that fixing it would save unbelievably vast sums.

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government. Without those special “risk management” schemes, a “socialized,” or “single-payer,” or “Medicare-for-all” scheme would just dump it all on the government, which is to say on all of us through taxes.

Various price-capping schemes over the years have transferred some amount of risk to the healthcare providers: If they can’t do the MRI or the blood test for the set amount of money that the health plan or the government is paying, they’ll lose money on it. But there was still no risk in selling unnecessary services, or doing them poorly.

For any system to work, it has to carefully balance risk and rewards, so that any player that can affect the system has to weigh those risks and rewards thoughtfully. As consumers, we do this all the time, every time we buy a car, go food shopping, or talk to a neighbor about who to hire to paint the house. **In traditional healthcare, we notoriously do not do this.**

Today, various “risk-balancing” schemes have arisen all across healthcare, with employers and health plans, and with healthcare providers. For instance, let’s take another look at Safeway.

Personal health accounts

What did the retail giant Safeway actually do to change the way its employees thought about the choices they made to use the healthcare system? To start with, it gave them some money.

Safeway junked all the HMOs and PPOs that it had used before. Instead, with its plan administrator CIGNA, it gave every employee a health reimbursement account (HRA) with \$1000 in it. The company completely covered a bunch of common tests and preventive and maintenance visits. For anything beyond those, the employee could use the HRA to pay for the first \$1000 of health expenses each year. But the second thousand dollars is completely on the employee’s dime. After that, they have to pay 20 percent of all costs until they have spent \$4000 in one year, then everything beyond that is covered. So the employees are at risk for their healthcare decisions. If they spend the money in the HRA foolishly, they will cost themselves money.

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As soon as Safeway made the change, suddenly all over the company, people are discussing which doctor costs how much, and talking about how they went to a retail clinic instead of the emergency room for a routine cold or flu, just as they would talk about the great deal they got on a barbecue on sale at Sears.

Rewards are “positive risk:” Do this, and you make or keep more money. Like risk, rewards work if they are the right size, and attached to the right measurements. Safeway’s voluntary “Healthy Measures” program reduces employees’ premiums by as much as \$1560 (for a family, per year) if they pass a test for smoking, weight, blood pressure and cholesterol. As a result, the smoking and obesity rates of Safeway employees are 30 percent better than the national average.²⁴

So getting your employees to share an appropriate level of risk has good results for both you and the employees. But what about the healthcare providers? How can we get them to take on more risk?

Actually, new practices are arising for doing just that. In dealing with healthcare providers, you must hunt aggressively for providers that use some of these practices. For instance:

Bundling and pricing

Here’s a simple transparency: Tell me how much this is going to cost.

Doctors and hospitals have traditionally wanted to say, “Well, every case is different.” But in fact, in much of healthcare they are not different, or at least shouldn’t be different. There are certain things that you need to do to put in a central line, or a mitral valve, to set a broken leg or assist in an uncomplicated birth. Unless something unexpected happens, or a complication shows up, the package of services and supplies needed for these is no more unpredictable

Rabbit



Risks and rewards can help change employees’ behavior and choices toward better and cheaper healthcare.

²⁴ “Mr. Burd Goes to Washington,” *Wall Street Journal*, June 19, 2009

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than those for, say, a valve job on your car. Doctors and hospitals should be able to say, “Here’s the package. Here’s how much it costs.”

“The package” is bundling: Take all the tests and procedures that go into a whole episode of care (an uncomplicated birth, a knee repair, a cholecystectomy) —from anesthesia to imaging, from diagnosis to rehab, from bed nights to pharmaceuticals—put it in one package, call it a “product,” put a price on it, and publish the price. “We charge so many dollars for cardiovascular stenting, so many dollars for a hip replacement.” A single price, a single bill, just like any other business.

Obviously, no hospital or doctor could bundle and price everything they do. But so far few bundle anything they do. **Push for bundles** for common, standard procedures.

Warranties

The next level of accepting ordinary business risk is to warranty your work.

A warranty is not a guaranty. A guaranty promises a good outcome: “If you don’t get the outcome we promised, we will refund your money.” That’s why they are rare. A beer commercial may show handsome young men drinking beer with beautiful young women, but the beer company won’t refund your money if you drink their beer and still can’t get a date. A warranty simply says, “We stand by our workmanship. If you have any problems with our product, we will make it right.” If the steak arrives burnt, the restaurant replaces it. If the patient develops an infection after an operation, or if the replacement valve develops a problem, the hospital will repair the problem at no extra charge.

Express or implied warranties are the norm in business. In fact, this is why you can go to Costco or your local car dealer, buy something and expect that at minimum it will work. Plug the toaster in, it turns on and doesn’t blow up.

Until now, healthcare has been the one exception. Doing sloppy work and causing the patient

Rabbit



Paying set prices for bundled healthcare products transfers some risk to the healthcare provider to get it right.

**Warranties
are the norm
in business.
That’s why
most things
just work.**

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a further problem typically just meant more business, another operation, more time in the hospital bed, more medications, all of it paid for.

Now Medicare and private payers are becoming more demanding. Increasingly they are refusing to pay at least for re-admits of the same patient for a related problem within 30 days of discharge. So hospitals and medical groups have, in effect, an implied warranty, at least for egregious and obvious problems. But hospitals and medical groups with express, written and publicized warranty policies are still rare. An express warranty is a sign of an organization with an usually high confidence in its quality, and its ability to control its processes. To have such a policy is to accept a risk—and a clear sign that the organization sees that risk as manageable.

Rabbit



Express warranty policies are a sign of an organization's high confidence in its ability to control its processes and deliver quality.

Capitation

The ultimate acceptance of risk in healthcare is capitation. Like Kaiser Permanente, capitated organizations take in a set premium for each patient, and in turn provide all their healthcare needs. This seems like a good idea: Put the provider at risk for the patient's health, and the provider will bend every effort to figuring out how to keep the patient as healthy as possible, as efficiently as possible. That's why Kaiser-like organizations are called "health maintenance organizations." In staff-model HMOs, doctors are paid to work in teams, and to be both efficient and effective.

As an example of the difference this makes, let me tell you one tiny story. I am a longtime Kaiser patient. Recently I discovered an odd bump on my hand. I suspected it was no big deal, but I wanted to be sure. I called Kaiser and got an appointment with my own doc for the next afternoon. It turned out that I was right: The bump was no big deal. But before I left the exam room, she had pulled up my entire patient record, inquired into every single condition I had from my asthma to my bum knee to my blood pressure medication, scheduled me for a yearly

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lab test I had been forgetting about, discussed my diet and exercise regimens with me, and given me two vaccinations—all in about 25 minutes.

In a strictly fee-for-service world, in which the doctor is paid per visit, few doctors would have tried to cram that much action into one visit, nor would they typically have had the resources for it (such as having the vaccines, lab records, and full patient record ready to hand). And I probably would have not bothered to come in for most of them, so my health would be worse off, and in the end the doctor would not have made the money for those extra visits, and I would cost the system more money with my worse health.

Still, **capitation is not a total solution**. The big problem at the core of capitation is simple: The provider can never actually take on all the risk for the patient's health. Much of a patient's health is determined by the patient, by their habits and lifestyle, what they eat and drink, how much they exercise, whether they see the doctor, whether they take their appropriate meds. An active and determined provider can influence some of that behavior, but they certainly cannot guarantee it. So putting all the financial risk on the provider puts the provider at risk for things they cannot fully control. In the current environment, an organization providing all possible services for a set price is often more expensive than other choices.

A capitated system is constantly seeking the right balance of incentives to get patients to lower their risk. In recent years Kaiser has instituted co-pays for most services: If you overuse the system, it's going to cost you. At the same time, Kaiser has gotten extremely active in tracking patients, getting them to come in for maintenance and preventive care, and making preventive care as convenient as possible (often through mail-in home lab tests).

The second major problem with capitation is that it is really hard to get it right. Most fully-capitated systems are generations old. Kaiser and Group Health of Puget Sound go back to the 1940s, the Geisinger system a generation earlier. They require from doctors, as well, a different kind of commitment and a different mindset from the usual fee-for-service work. Morphing into a fully-capitated system is not a realistic possibility for most hospitals and health systems.

The second big problem with capitation is that it's hard to get it right.

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If you have a fully-capitated system in your area, you may want to offer it to your employees. But by covering everything, such a full staff-model HMO takes some of the levers for influencing behavior and driving down costs out of the employer's hands.

Mini-caps

Some healthcare providers take on a modulated amount of risk by taking capitated contracts for certain chronic conditions: A diabetes-care subscription, for instance. For a set annual fee, they give the patient all the diabetes-related care they need. The amount and types of care needed for a particular chronic condition is fairly well known and quantifiable. And since such care usually actually reduces the patient's overall healthcare costs, an annual subscription can make sense for an employer.

Put a crew on it, share risk

Notice how these first two parts work together. Getting seriously involved in your employees' health can make them healthier and drop their costs—but to do that, you have to influence their choices and behavior, as well as the choices and behavior of the healthcare providers. Risk and rewards drive behavior. Finding ways to get everyone in the system to take on appropriate risk helps everyone make more sensible choices.

Rabbit



When a healthcare provider offers a subscription for care for a particular syndrome, it's a sign that they know what they are doing and are operating systematically to control their quality. If they didn't they would lose money and customers.

**Risk and rewards
drive behavior.**

The 5: A Framework

3. Swarm the employee

You may have gathered by now that this is not about reducing costs by “cost cutting,” by any form of rationing, by denying services to your employees. This whole strategy turns on the observable, provable fact that helping people stay healthy is cheaper than paying for treating their disease. And helping them manage their chronic condition is cheaper than paying for heart attacks, strokes, diabetic shock, ambulance rides, operations, disability, turnover, and early retirement. Not just a little cheaper. Way cheaper.

So in this strategy, **we make no attempt to give the employees less healthcare. We give them more of the right kind of healthcare.** And that’s what costs less.

So you provide them with everything that seems to make a difference—because if you can drive down the acute side of the side of the scale at all, the savings are huge.

Let’s take a look first at some surprisingly minimalist examples that save lots of money.

Talk to your pharmacist

HealthMapsRx is a partnership with employers and networks of community pharmacists to improve the health of employees. The pharmacists are given basic training in being “health coaches” for employees of local businesses with chronic health problems. The pharmacist gives the employee’s physician a report after every visit, and refers any problems that need attention to the appropriate clinician. A year-long test, the “Diabetes Ten-City Challenge,” concluded in 2009, showed that even such simple coaching could save an average of seven percent of total healthcare costs (counting the costs of the program). The pharmacists helped the employees track their A1c, blood pressure, and cholesterol, and manage their disease through exercise, nutrition, and changes in lifestyle. And it seemed to work: The employees improved on every metric from A1c scores to body mass index and eye exams.

Hat



Giving employees more of the right kind of healthcare costs far less than giving them less of the wrong kind of healthcare.

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Notice: The patients didn't save seven percent of the cost of their diabetes; they saved seven percent of their total healthcare costs. **That's a lot of success on the cheap.** Pharmacists are well-deployed throughout the community, and feel a lot more available than doctors and nurses—and the cost is zero to the employee and minimal to the employer.

The HealthMapsRx diabetes program is now expanding nationwide, supported by Glaxo Smith Kline and the American Pharmacists Association, which is running similar programs for asthma, cardiovascular disease, high cholesterol, and osteoporosis.²⁵

Tracking chronic patients

This is a very similar story, though it involves primary-care doctors and nurses, rather than pharmacists: Geisinger, in northeastern Pennsylvania, is an integrated system, working mostly with its own hired physicians. But its insurance company, Geisinger Choice, insures many patients of independent doctors in the area. Geisinger went to these independent primary care physicians with a deal: "We will place and pay for an extra nurse to work in your office. Her sole job will be to keep track of your chronic patients. We believe we will save money by doing this. We will share the savings with you 50/50, if you promise to spread that rebate out across your whole staff."

How much did they save from this simple intervention? Exactly the same as the simple HealthMapsRx intervention: an 18 percent reduction in hospital admissions for those tracked patients—and a seven percent reduction in their overall healthcare costs. Seven percent seems to be some kind of baseline. It's the number printed on the low-hanging fruit.²⁶

The next story, though, involves government, and a completely different kind of patients.

Seven percent savings seems to be some kind of baseline.

Rabbit



Just tracking chronic patients and giving them a little coaching seems to save about seven percent of their overall healthcare costs.

²⁵ HealthMapsRx.com

²⁶ Abelson R, "A Health Insurer Pays More To Save," NY Times, June 21, 2010

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Making money by making the poor healthier

If you were to look around, as an entrepreneur, for a way to make money by helping some population be healthier, what populations would seem like the “low-hanging fruit”? Would you think, “Ah, yes! Frail, elderly people on Medicaid in state-supported convalescent homes! And kids on Medicaid with disabilities!” Probably not. And yet that is exactly what happened in Illinois. McKesson’s disease management subsidiary contracted with the state to provide its Your Healthcare Plus services to just such populations. Teams of doctors, nurses and case managers, many of them on-site across the state, working with the patients’ existing providers, measurably improved the health of these patients. Counting the costs and fees for running the program, McKesson saved the state of Illinois \$307 million in the first three years of the program—by giving people more services of the right kind of care and attention, not less.²⁷

Hat

Giving any patients more of the right kind of healthcare drops the cost for whoever is footing the bill

Swarming

Let’s ramp it up. The minimalist examples save seven percent. What does it take to save double or triple that amount?

It takes more. **It takes true swarming:** Getting the employee every kind of help that helps, in language they can understand, in ways that make them comfortable, in shapes they can engage with, with incentives they find interesting.

Think of the Boeing and CIGNA examples. These are not a few pamphlets, a few fliers on the bulletin board, a meeting or two. These are both examples of a full-court press, working in-your-face with the employees who volunteer to be part of the program. The Boeing employees got full physicals, health risk evaluations, a personal health coach. They got routed to the appropriate clinician to deal with their conditions, and the health coach helped them keep on

²⁷ McKesson Corporation case study, “Illinois: McKesson Program Generates \$300+ Million Net Savings in Three Years,” 2010

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track. They set them up with gym memberships, helped them find workout partners, whatever would help. They swarmed them.

Information

If we are depending on people to make smart choices, they need to know a lot about what the choices are, how much they cost, how good they are, what results they can expect. The CIGNA Choice Fund, for instance, gives the employees all kinds of information. Customers have a personalized web site that will tell them the actual cost of the drugs they take at drug-stores within any distance they want to set, or the actual recent charges for common procedures such as an uncomplicated birth or a hip replacement.

Care Solutions, a division of UnitedHealth Group's subsidiary OptumHealth, offers a similar array of information, including health risk assessments, personal health records, and interactive health coaches, through customized health and wellness Internet portals offered by United and some 1000 other organizations, as well as a free portal offered directly to consumers, www.myOptumHealth.com.

OptumHealth's information platform, eSync, collects and synchronizes a huge array of information on each customer, including medical claims and pharmacy information, lab results, information from the patient, and other data about the customer's behavior and stage of life. eSync digests all this data and returns personalized recommendations on potential health issues and lifestyle risks. These recommendations are then used by OptumHealth's personal health consultants (nurses, wellness coaches, and behavioral health specialists) when they talk to the customer. The same recommendations turn into health messages delivered to each individual through their health portal, email, mail, or phone calls—however the customer wants to receive them.²⁸

**Actual costs,
what actually
works, in real
time.**

²⁸ Company information, April 6, 2009

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Online healthcare

Convenience is clinical. People often make medically poor or expensive choices, taking a minor problem to an Emergency Department, for instance, or neglecting to see a doctor at all when they should, because medical care is inconvenient. It's across town, it's not open in the evening, or you can't get an appointment for weeks.

Employers can make basic healthcare a lot more convenient in several ways. One is to take it online. For some time now, people have been turning to the Internet to get health information. Now they can get actual medical care online from live doctors. In fact, one forecaster predicts that by 2013, one quarter of all patient encounters in North America, Western Europe and the Asia/Pacific region will be virtual.²⁹

You want to talk to a board-certified doctor, or a licensed mental health professional, right now, by phone, email, chat, or web-cam videochat? That will be \$59.95 at MDLiveCare.com. Sign up, and you get the better deal—\$9.95 per month, \$99.95 per year, each call is \$39.95 and the first one's free. For \$129.95 per year you can include your whole family in the deal, and the first two calls are free—and they can do lab work, fill prescriptions, and keep your medical records, too.

Employers can opt to cover such the use of such online services directly, in hopes that it will drive down the usage of more expensive services, and the time people take off work to use them, as well as make sure that people get their problems attended to promptly. The service should be able to access all of the patient's records (with permission) via Google Health or Microsoft's HealthVault service.

OptumHealth offers a similar service through American Well, with the medical

Rabbit



Make basic healthcare both inexpensive and convenient for your employees, and you'll spend a lot less money.

²⁹ V Shaffer *et al.*, *Gartner Predicts 2009*: "Healthcare IT Moves from Transactional to Transformational," January 27, 2009

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records synced through its proprietary eSync platform.³⁰

Onsite clinics

Some employers are turning to onsite clinics which are, as the website of WeCare TLC clinics puts it, “Not your grandfather’s company doctor.” The number of companies with onsite healthcare clinics has been growing, with nearly a third of the Fortune 500 companies having one by 2009. But their growth stalled with the recession, except for one segment of that market. Clinics built on an advanced model designed to drive patient health continued to grow. The WeCare TLC clinics, for instance, use onsite nurse health coaches, evidence-based medicine, full digitization, registries, and an array of other tools to become “fully-realized medical homes and integrated full-continuum medical management machines located in the front end of the care delivery system,” according to Brian Klepper, WeCare TLC’s Chief Development Officer. The chain will have expanded to 13 onsite clinics in five states by the beginning of 2011. Klepper claims that, depending on the local situation, clients who install a WeCare TLC clinic can expect a rapid 25-35 percent reduction in health-care costs.

A rapid 25-35 percent reduction in healthcare costs.

The business model is simple: The client pays the up-front costs to install the clinic. One client, for instance, is the union for the civilian laborers at a submarine base in Georgia. The capital cost of installing the clinic was less than one month’s healthcare costs for the union. Once it’s up and running, WeCare TLC bills the client for the actual itemized cost of running the clinic, from salaries to drugs, plus a management fee. There is no insurance involved, but for a self-funded employer, much of the employees’ regular utilization of outside doctors goes away, because the clinic is so much more convenient.

The model offers something for everyone. The employee still has their usual array of choices. They can use their insurance to go to whatever doctor they want. But if they go to the onsite clinic, not only is it far more convenient, but there is no co-pay, and no payment for

³⁰ <http://www.optumhealth/esync>

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pharmaceuticals. Experience shows that employees with such a clinic are much more likely to stay on track with their chronic syndromes. The employer gets not only a lower and better-controlled healthcare bill, employees take less time off for doctor visits, and are less likely to be absent for problems that were not adequately taken care of up front. The doctors involved typically make more money at the clinic than in a regular practice, especially since they waste no time arguing with insurance companies or filling out forms. All they do is treat patients. This is the combination we are looking for across healthcare: Better health for less money.

This is the combination we are looking for across healthcare: better health for less money.

The rule of thumb in the past has been that an onsite clinic only makes sense when the employer has a minimum of 750-1000 employees at a single site. With aggressive medical management and scalable hours, WeCare TLC has made it work economically at sites with as few as 62 employees.³¹

Put a crew on it, share risk, swarm the employee

Notice how these first three parts work together. **Getting seriously involved in your employees' health** can make them healthier and drop their costs—but to do that, you have to influence their choices and behavior, as well as the choices and behavior of the healthcare providers. **Risk and rewards drive behavior.** Finding ways to get everyone in the system to take on appropriate risk helps everyone make more sensible choices. **Swarming the employee** gives them many opportunities and methods and prods to change their behavior and make sensible choices.

³¹ B Klepper, WeCare TLC; W Montoya, Montoya Benefits; Presentation at Health 2.0, San Francisco, October 7, 2010
B Klepper, private communication, October 15, 2010

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4. Target populations

We now have several decades of serious research and experience into population health, building healthy communities and changing the behavior of groups of people. Some key points emerge from this research, points that are important to think about if you are trying to influence the health and the medical costs of your employees.

A lot of research has asked the question: Is it better to give out general health messages, or to target particular at-risk groups? Some studies have drawn the conclusion that you get a better return on investment if you just give out general health messages, trying to keep well people healthy, rather than targeting people who are at high risk.³² Experience, and many other studies,³³ suggest that this may be the wrong conclusion to draw from the data in these studies.

The conclusion to draw from decades of experience and studies is threefold:

1. **You can get disproportionate results** by targeting the populations that incur the greatest healthcare costs.
2. **The best strategy is to do both:** a comprehensive program that aims to help all employees improve or maintain their health, coupled with targeted help for high-risk groups.
3. **It takes time.** Though some results will show up rapidly, it may take two to three years for full results to show up.

The most obvious and easily-measured example of targeting arose in the 1980s and 1990s, as health authorities combatting the spread of the HIV virus attempted to convince people to use

Hat



The best results come from combined general and targeted health improvement programs, practiced consistently over several years.

³² Edington DW, *American Journal of Health Promotion* 2001; 15(5): 341-349

³³ D Zank, D Friedsam, *Employee Health Promotion Programs: What is the Return on Investment?* Issue Brief, Wisconsin Public Health and Health Policy Institute September 2005

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condoms when they had sex. General messages (such as ads on bus stops and billboards) had relatively little effect. Most of the population had little possibility of exposure to the virus, and was more concerned about such bogus vector scares as mosquito bites, water fountains and toilet seats. What really made a difference in the end was messages in gay bars, at Gay Freedom Day celebrations, and person-to-person through gay social networks, targeted directly at the group most at risk, in language they could hear, using images of people with whom they could identify.³⁴

People hear and act on health information from people or institutions they trust, in language they actually use, mediated by people they see as being like them.³⁵

One example: In the 1990s, facing the possibility of “managed care” and other types of healthcare reform, one hospital system in the Midwest felt it needed to gain experience in handling healthcare for the poor. So they decided to give away free health-care to 400 families that could not afford it. They put together a fully-paid insurance program that would last one year, after which they would seek funding to continue the program. They printed up enrollment forms and temporary insurance cards, and then the executive team themselves marched off into the poor and immigrant part of town to hand out the goodies.

They had no takers. Not one household signed up for free healthcare for them and their children. Nobody believed the hospital executives.

They asked their consultant, the great healthcare visionary Lee Kaiser, what they did wrong. Kaiser, an older white guy in a suit, said, “Who would believe you? You’re a bunch of older white guys in suits, saying, ‘We’re from the big bureaucracy on the hill, and we’re here to give you something free.’” Kaiser convinced them to convene a meeting of the pastors of the

People act on information from trusted sources, in language they use, through people they see as being like them.

³⁴ Author’s contemporary interviews with CDC experts, local public health authorities, and AIDs activists

³⁵ The best book on this is John Seely Brown and Paul Duguid, *The Social Life of Information*, 2000

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various churches and mosques that served that population. They came and listened. The following weekend, they accompanied the executives door to door in their parts of town. Four hundred families signed up in one weekend.³⁶

Who is the target?

To “target” some group is simply to make sure that a member of that group feels that there is something for them in your program, that it’s not just for “people who don’t have my problems.”

What groups should get special attention? Any definable group whose health issues:

Typically cost more, both in medical attention and in lost work hours and productivity, and

Can be managed so that they cost less.

Health status target groups

The most common and obvious groups are defined by health status, such as:

- People with **diabetes**—as we saw earlier, simple information and coaching can shave seven percent off of their total medical costs
- People with **high blood pressure**, called “the silent killer” because it doesn’t necessarily show symptoms—yet it can be easily and effectively managed
- People with **heart disease**, still the top killer and disabler of Americans
- People with **metabolic syndrome**, a group of issues (including central obesity and insulin resistance) that greatly increase the odds of heart disease, diabetes, and stroke
- **Overweight and obese** people
- **Smokers**
- People with **substance abuse** problems

Rabbit



You will save money by paying special attention to those who cost the most.

³⁶ Author contemporary interviews with Lee Kaiser and the health system’s executives

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Life stage target groups

People in certain life stages are more likely to have costly health problems. These include:

- **Parents of young children**, who often must take time off work to deal with a sick child
- **Peri-menopausal women**, who often have a wide range of problems, often sub-clinical results of fluctuating hormone levels, which can lead to prolonged mental and physical fatigue, weight gain, and susceptibility to infections.
- **People close to retirement age**, beginning to show the effects of age in their 50s and 60s

Convenience target groups

People in certain work groups or shifts are more likely to have skip your programs and not be part of your drive for lower costs. These include:

- **People on different shifts**, if their schedule makes it difficult for them to use the onsite clinic, attend health classes, or meet with their health coach
- **People on different work sites**
- **Road warriors**

Here's a story about convenience: You drink beer? Maybe you should buy one for Carlos Olivares. Three quarters of all the hops in the U.S. come from the thousand square miles of the Yakima Valley in eastern Washington state. You can't have beer without hops. You can't have hops without farm workers to plant them, irrigate them, harvest them, and load them into trucks bound for the breweries. The growers know that you can't have farm workers if somebody doesn't patch them up when they are injured and dose them when they are sick. That's Carlos, and the doctors and nurses he employs. The small, soft-spoken, energetic man from Bolivia has run the Yakima Valley Farm Workers Community Clinic for 25 years. He does things that are simple, basic, and smart, things that go right to the point, like this: He convinced local doctors to open after-hours clinics so that the farm workers don't have to drive all the way

**Get to people
where they are, in
the situation they
are in, in language
they understand.
That's what works.**

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to the hospital in Spokane and show up in the Emergency Room when all they have is the flu, or an infected cut. Farm workers don't have much money, and most of them don't have health insurance, so doctors weren't interested. They have practices to run, and bills to pay. So Carlos did the math, put together a PowerPoint, called a little meeting, and showed the doctors that they could actually make a good bit of money at it, all by saving money for the poor farm workers, and making it easier for them to stay healthy at the same time.

The doctors who took part nearly doubled their income. The farm workers were healthier. The agricultural giants who grow the hops got better, more productive workers—and they weren't even paying for health insurance for these employees. Would be smart of the agribusiness companies to subsidize the clinics to keep the workers even healthier? Yes.

Information style target groups

People have a lot of different ways of taking in information. People don't necessarily like reading bulletin boards. Or don't like reading, period, if it's complex information. Some people prefer to hear it in person. Others prefer the phone. Others prefer a web site. Or cell phone text messages. Or short videos. Some people like exercise classes with their co-workers. Some hate them.

People will avoid your program if it's not delivered the way they like. Your opinions on how they should access just don't count. If you want to really engage people, you have to meet them where they are, in the information style that they will listen to.

You as an employer do not have to create all this information in all these styles. There are companies who are very good at exactly that: Employee health information.

Put a crew on it, share risk, swarm the employee, target

Notice how these first four parts work together:

- **Put a crew on your employees' health**—making them healthier and dropping your costs.

Your opinions on how people should get engaged with their health just don't count. They will do it the way that suits them.

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- **Share the risk and rewards** to influence the choices and behavior of both your employees and of healthcare providers.
- **Swarm the employee** with opportunities and resources.
- **Target** specific types of employees.

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5. Shop

Probably the most widely-held American belief, so widely-held we don't think of it as an act of faith but more like the law of gravity, something we say reflexively to our kids, to our friends, to each other, at work, is the saying: "You get what you pay for."

That's not true in healthcare.

More than in any other industry, in healthcare as it is traditionally run we have no idea what we are paying for, or even how much we are paying.

**"You get what
you pay for?"
In healthcare?**

That is changing, and you as an employer need to help make it change.

More and more tools are arising that help us understand what we are going to pay, and what we are going to get for that money. OptumHealth, the national Blue Cross/Blue Shield Association, CIGNA and other groups have invested heavily over the last five years in amassing and analyzing vast databases that tell them, for any particular condition, who takes care of this best? Who does it most cost-effectively?

Prices can vary by ten times or more, with no indication that you're getting any greater quality. It's amazing what a close analysis of claims information will tell you. When Safeway first began running the data, for instance, they found that the price for a colonoscopy within 30 miles of their headquarters in California ranged from \$700 to \$7000.³⁷ When a healthcare provider refuses to give prices (even though the claims data show actual past charges), the CEO of Safeway, Steve Burd, has been known to call the provider's CEO and ask him or her to let him know when they plan to shop at Safeway, so they can take all the prices off the shelves.

³⁷ "Mr. Burd Goes to Washington," *Wall Street Journal*, June 19, 2009

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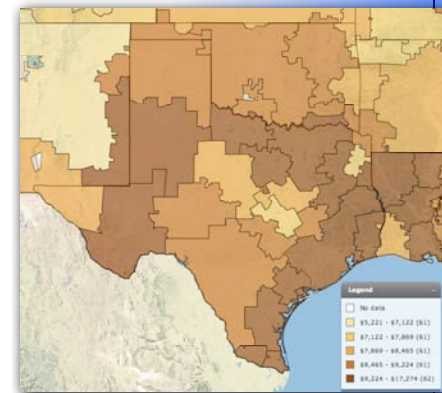
Similarly, prices for drugs—the same drugs from the same manufacturer, in the same bottles—can vary astonishingly from one source to another.

Systemic cost

Remember: **You are not buying individual items of healthcare.** You are buying the cost of healthcare per year per employee. Which means that the cost of individual procedures or drugs only tells part of the story. One system can cost less than another, even when they are charging the same per item.

One of my favorite examples: the map of Medicare cost variations in Texas. Some areas cost the government twice as much per person as other areas—often areas that are within a hundred miles of each other and not that different in socioeconomic make-up. The darker the area, the more it costs. But what's the light area smack in the middle of the state? When I ask this of audiences familiar with Texas, they don't name the town (Temple), they name the medical group: Scott and White. It's one of the largest integrated group practices in the nation, including 10 hospitals and hospital partners, more than 60 clinics, and a health plan, with total staff exceeding 12,000, including over 1,200 physicians, scientists and other health care providers. When, in 2009, the Institute for Healthcare Improvement invited representatives from the top 10 regions of the country in terms of both quality and cost (or improvements in both) to ask them, in the name of the conference, "How Did They Do That?", Scott and White executives were among those invited.

Similarly (though it is smaller and has less impact on the costs of the whole area), in Houston, the 350-physician Kelsey-Seybold Clinic has used evidence-based medicine, a collegial and cooperative culture, and a strong strategy of coordinating care to drive down costs an average of 13-15 percent per year.



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How to shop for healthcare providers

Of course, price is only part of the value test. How do you evaluate how good the healthcare is that you are paying for? Are the ones that cost more worth it?

Multiple rating sites have arisen, some relying on consumer satisfaction surveys (such as those aggregated on www.ConsumerHealthRatings.com). The government site hospitalcompare.hhs.gov rates thousands of hospitals across the United States for customer satisfaction, but also for a number of measures of process quality (such as the percentage of surgical patients who receive an antibiotic at the right time) and outcomes quality (such as what percentage of surgical patients actually get infections).

Clinical markers

Can you make any judgments yourself about the likely level of quality of local institutions and medical groups? Yes, actually. While only a few of these markers rate as “must haves,” there are a number of markers that in aggregate can tell you a lot about how good your local providers are. They include:

- Do they keep **electronic medical records**? Most organizations still do not, but the industry is in rapid transition. EMRs are at this point a sign of a more well-organized, forward-thinking system.
- Are these EMRs **compatible with Google Health or Microsoft’s Health Vault**, so that they can become part of the patient’s medical record? This is actually rare so far, but is a key piece of a better and cheaper healthcare system.
- Do they use **computerized order entry** for tests and pharmaceuticals, and a **picture archive and communications system (PACS)** for images? These are key markers of a strong patient safety program

Hat



You can make legitimate judgments about which healthcare providers in your area provide the highest quality for the money.

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- Do they use **checklists** for surgery and critical procedures? These are also markers of a strong patient safety program.
- How do they **measure** their clinical processes and outcomes?
- Do they track patients with **patient registries**? This is the core of the primary care “medical home” rubric.
- Do they at least claim to practice **evidence-based medicine**? Anyone who says, “No, I prefer the other kind” should be struck off of your list instantly. Some clinicians still give various excuses for following their own habits and quirks rather than strong medical science backing the best practices established by the top practitioners in their field. We need to respect their point of view—and take our business elsewhere.

Organizational markers

Other markers of a highly-organized, efficient system are organizational, such as:

- How **transparent** are they about real charges and outcomes?
- Do they offer **bundled products with prices** such as a total hip replacement or a diabetes subscription? This is one way that clinical organizations appropriately share financial risk for the outcome of cases. It is also a strong sign of an organization that has a firm grip on its processes, driven by strong clinical teamwork.
- Do they give **warranties** for their work? This is still rare, but once again: This shows shared risk, good process management, and strong teamwork.
- Do they at least claim to be an “**accountable care organization**,” or part of one? How do they show that? An “accountable care organization” is a clinically-integrated, Mayo-like organization designed to cut costs and raise quality. It may be a virtual network—everyone in it may not be receiving a paycheck from the same organization—but it must be contractual, with a financial structure, not just

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- a set of friendly promises between clinicians. This is another way of sharing financial risk.
- Does their primary care operate on a “**medical home**” model? In what way?

The new management toolkit

Healthcare is a production system, a massive one with very high demands and expectations, huge and exacting transfers of information and material, meticulous manufacturing and processing needs—and until recently almost no introspection about processes. In most of healthcare even now people do things the way they do them because that’s the way they have always done them, or that’s the way it’s convenient for this or that doctor, or for thousands of other reasons that have little or nothing to do with what is the most efficient, effective way to get something done. You want to work with organizations that can say, “We know this is the best way to do this because we have tried other ways and measured the result—and we’re still looking for better ways.” Healthcare, in its core processes, is enormously wasteful, simply because its processes have never been studied and improved.

Lean management, the theory of constraints, benchmarking, six-sigma process quality, checklists, continuous performance improvement—a whole array of tools have been tested and refined in other industries, and are beginning to gain a foothold in healthcare. Their successes, when applied diligently and enthusiastically over time, have been remarkable and measurable.

To take just two examples:

- Seattle’s Virginia Mason a decade ago famously devised its own version of the “Toyota Production System,” dubbed the “Virginia Mason Production System.” Over just a few

Hat



Well and vigorously managed organizations can take better care of your employees at lower cost.

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years it drove inventory down by half, lead time by 53 percent, while driving productivity up 44 percent (the equivalent of hiring 77 new full-time employees), and saving some \$12-15 million per year in capital costs.³⁸

- Seattle Children's in-patient psych ward cut length of stay in half (from 20 days to 10), and increased the number of kids it could help from 400 to 650 per year, without adding new beds, all while patient satisfaction rose. The hospital as a whole cut per-patient costs by 3.7%. It estimated its savings in 2009 at \$23 million—while serving 38,000 patients, a 41% increase just since 2004, with no new beds.³⁹

Work with providers

Here's a story: A few years ago, executives of Aetna in the Seattle area had a meeting with the executives of Virginia Mason Medical Center. The dialogue went something like this:

Aetna: We're establishing a new premium network of the highest quality healthcare providers in the area.

VM: Great! We are very high quality, and can prove it.

Aetna: But you're not going to be on the list, because you cost too much. For many things you cost twice as much as other high-quality providers.

VM: Whoah, hold on, let's talk about this. Show us the problems.

Aetna, analyzing its claims data, actually had a clearer picture of the cost per episode of different diseases and problems. Virginia Mason actually had no idea until then how their overall costs stacked up against other providers. But Virginia Mason already had a strong grip on its practices, and employed all its doctors in a strong team environment. So it set out to

³⁸ R Bohmer, E Ferlins, "Virginia Mason Medical Center," Harvard Business School case study, October 3, 2008

³⁹ J Weed, "Factory Efficiency Comes to the Hospital," *New York Times*, July 9, 2010

The 5: A Framework

discover why it cost so much, and rectify the situation. It asked Aetna's medical director, Dr. Don Storey, to present Aetna's findings to all of Virginia Mason's 26 department heads. Then Virginia Mason's chief of medicine, Dr. Robert Mecklenburg, set out to talk directly to the employers.

For instance, one of the big employers in the area that Aetna worked with was Starbucks. What do you imagine is one of the main health problems of Starbucks baristas (besides insomnia)? Back problems. They work standing up all day. Virginia Mason operates a major back clinic. Dr. Mecklenburg, went and sat down with the benefits director at Starbucks, Annette King, to talk about the problem—which in itself surprised King. She later told a reporter, “I couldn't believe a doctor was making an appointment with me and asking what I wanted.” She ran through Virginia Mason's process along these lines: Look, when we refer a Starbucks employee to you for back trouble, the first thing you do is pop them in an MRI. Then they have to come back sometimes weeks later for an interpretation of the scan. But most of those MRIs don't tell you anything you didn't already know. It turns out that 85 percent don't need anything more than physical therapy and painkillers—surgery or other invasive procedures are actually not the best thing for them. What would it hurt if you were to do a quick triage when they walked in the door to determine whether they had an obvious serious, problem, then give all of them some painkillers and a referral to physical therapy right there, and then see them again only if they don't improve? That's what the medical literature says, anyway. That would be faster and less inconvenient for the employee, and far cheaper for us.

In traditional healthcare, no medical director would ever have asked an HR director for any ideas about clinical processes. It was a sign that we are turning the corner into a new era when the medical director said, “Let me talk to our back docs about that.” He did talk to them, and

Rabbit



In the evolving “consumer-driven” healthcare market, it is increasingly possible for large employers—or groups of small employers through their health plans—to push back directly on healthcare providers' high costs and inefficiencies.

The 5: A Framework

they redesigned their processes the way the HR director had suggested—and found they had the capacity to deal with five times as many patients.

But there was another step: Because of the sunk costs of the imaging center, Virginia Mason now found that they were losing money on every case in which they did not do an MRI. Virginia Mason went back to Aetna and Starbucks for a slight upward adjustment of the amount they were paid per office visit and per physical therapy visit. This put them back in the black, even at far lower charges per episode.

Now driving not only for quality but for cost-effectiveness, Virginia Mason made similar process adjustments in a number of other areas demanded by Aetna and the employers.⁴⁰

Put a crew on it, share risk, swarm the employee, target, shop

Finally, notice how all five parts work together:

- **Put a crew on your employees' health**—making them healthier and dropping your costs
- **Share the risk and rewards** to influence the choices and behavior of both your employees and of healthcare providers.
- **Swarm the employee** with opportunities and resources.
- **Target** specific types of employees.
- **Shop** aggressively for the best and most cost-effective healthcare providers—and use your market leverage to push them to become better and cheaper.

⁴⁰ “A Novel Plan Helps Hospital Wean Itself Off Pricey Tests,” *Wall Street Journal*, January 12, 2007

Next Steps and Resources

Next steps

Where do you go from here?

You need some tools: Resources. Strategy work. Evaluations. References. Study guides.

Re-setting your strategy

The Change Project (<http://www.TheChangeProject.com>) and its project on building the next healthcare, Imagine What If (<http://www.ImagineWhatIf.com>): We can help, through consulting, board and executive retreats, speaking, and educational materials such as this report.

Forthcoming: We are preparing a series of train-the-trainer PowerPoint decks, evaluation guides, and workbooks with which companies can help their executives, HR departments, and employees re-think the company's relationship with the employees' health and healthcare.

Background learning

Publications that can give a deeper understanding of the background thinking behind the Framework, especially in understanding the changes the healthcare field itself is going through, include:

Papers by the “Dartmouth Group,” researchers (mostly physicians and statisticians) centered on The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Group, whose best-known authors and analysts include John Wennberg, M.D., Ph.D. and Elliot Fisher, M.D. Wennberg is the pioneer and leading researcher of unwarranted variation in the healthcare industry. A collection of the Dartmouth Group's seminal papers is available here: <http://content.healthaffairs.org/cgi/content/full/hlthaff.var.112/DC1>. There are various technical arguments about the details and conclusions of the work of Wennberg and the

Next Steps and Resources

Dartmouth Group, but the cumulative weight of two decades of studies is, I believe, undeniable: There are large variations in the cost of healthcare in different areas of the country that do not correspond to better outcomes, and that cannot be ascribed to differences in the health of the populations, socioeconomic status, state regulation, or any other relevant marker except for variations in the structure of the local medical marketplace.

Shannon Brownlee: ***Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer***, Bloomsbury USA 2008. Healthcare journalist Brownlee popularizes Wennberg's journey and findings. It's a highly readable and rather astonishing book.

Michael Porter and Elizabeth Olmstead Teisberg: ***Redefining Health Care: Creating Value-Based Competition on Results***, Harvard Business Press 2006. Competition and competitive advantage guru Porter and healthcare analyst Teisberg attack the problem of why competition does not seem to work in healthcare to bring value to the customer. Their answer: There is competition in healthcare, but it is at the wrong level, over the wrong results, for the wrong customer. Business models that made their money by bringing measurable value (outcomes per dollar) to the end customer (the patient) would bring true competition to bear on healthcare.

Regina Herzlinger: ***Who Killed Health Care?: America's \$2 Trillion Medical Problem - and the Consumer-Driven Cure***, McGraw-Hill 2007. Herzlinger, another Harvard professor, is the leading advocate of consumer-directed healthcare.

Clayton Christensen, Jerome Grossman, M.D., Jason Hwang, M.D., ***The Innovator's Prescription: A Disruptive Solution for Health Care***, McGraw-Hill 2008. Christensen, yet another Harvard professor, is author of *The Innovator's Dilemma*, which popularized the idea of the need for "disruptive innovation." Here, with two physicians, he analyzes healthcare. The upshot, as detailed earlier in this book, is that the primary business model of healthcare (insurance-funded fee-for-service) does not match the needs of the healthcare market. Like Porter and Teisberg, they find that an array of business models that delivered value in various healthcare niches would greatly shift the marketplace of healthcare for the better.

Next Steps and Resources

Idea farms

Here are a few places that I look to for ideas for understanding what the healthcare system is going through:

The Health Care Blog (<http://www.thcb.com>), founded by Matt Holt, has consistently focused on the leading edge of change in healthcare, with a fairly agnostic style, welcoming all comers. The blog has a number of guest bloggers in addition to Holt, from across the industry, and is known as a place where people trumpet new ideas, pilot projects, enlightening studies, and provocative points of view.

Health 2.0 conferences (<http://www.health2con.com>) As the web site says, “The Health 2.0 Conference is the leading showcase of web-based and mobile technologies transforming the healthcare system.” It is also a showcase for emerging ideas about the system as a whole, not just about its technology. Spawned by The Health Care Blog, and run by Holt and co-founder Indu Subaiya, Health 2.0 conferences typically happen in the fall in San Francisco, then in the spring somewhere else in the world. As the web site again puts it, “Health 2.0’s original tag line of ‘user-generated healthcare’ contains the germ of a compelling idea—patients are using new tools to guide their own care. And now those tools are starting to integrate with the health care system.”

Institute for Healthcare Improvement (<http://www.ihl.org/about>) IHI was founded in the late 1980s by current Center for Medicare and Medicaid Services administrator Don Berwick, M.D., a pediatrician, and a group of visionary individuals committed to redesigning health care into a system no longer plagued by errors, waste, delay, and unsustainable social and economic costs. Especially in recent years, it has generated an extraordinary array of practical knowledge, results from the field, guidelines, and “bundles” of best practices that can be profoundly useful in understanding what constitutes highest quality when you are shopping for healthcare providers.

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